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'The Human Prerogative': A Critical Analysis of Evidence-Based and Other Paradigms of Care in Substance Abuse Treatment

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Abstract Present-day substance abuse treatment is characterized by a compelling demand for applying evidence-based interventions. Vehement discussions between policymakers, practitioners and researchers illustrate this clash of differing paradigms. The aim of this article is to situate evidence-based practice among the leading paradigms of care and to elucidate its implicit assumptions and potential implications. Evidence-based practice is inherent in the empirical-analytical paradigm of care and science, founded upon randomized and controlled studies. This paradigm is compared with the phenomenological-existential and the critical post-structural paradigm, which focus on elaborating the human potential and exploring individuals' subjective interpretations, and on criticizing social inequalities and striving for compliance with human rights, respectively. Evidence-based practice and the methodological rigidity in each paradigm are analyzed critically. We conclude that through the dialectical integration of these diverse approaches, evidence, existence/humanism and social emancipation can be combined for the benefit of the human prerogative of care.

Keywords Addiction · Treatment · Research paradigm · Evidence-based medicine · Therapeutic communities · Harm reduction

Introduction

Evidence-based practice is currently considered to be an important prerequisite to realizing quality of care and has also found its way into substance abuse treatment. In various countries, the need for the implementation of evidence-based interventions and guidelines is emphasized repeatedly and increasingly by researchers and policymakers

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[1–6]. According to some authors [7, 8], the field of substance abuse treatment is even moving towards a binding demand for the use of evidence-based standards in which the reimbursement of costs will gradually be tied to the delivery of evidence-based interventions.

This tendency may have far-reaching consequences for daily practice since practitioners are afraid that substance abuse treatment will be limited to interventions which have been proven to be effective in randomized and controlled trials or will wipe out the subjective component in treatment [9]. Such concerns were also expressed by clinicians, treatment providers and researchers at various national and international conferences in Brussels (Belgian Federal Science Policy, March 27, 2007), Thessaloniki (Society & Mental Health Conference, October 20–21, 2007[1]), Oslo (European Working Group on Drug-Oriented Policy Research, October 1–3, 2007) and Oxford (Oxford Science Meeting for Therapeutic Communities, March 31–April 1, 2008). Similar reactions were observed during a study we made concerning the implementation and application of evidence-based interventions and guidelines in Belgian substance abuse treatment [10]. Strikingly, in the French-speaking part of Belgium (the Walloon provinces), which has a strong psychodynamic treatment tradition and is more closely oriented to the Latin tradition and the Southern European countries, the opposition towards the evidence-based paradigm is much stronger than in the Dutch-speaking part of the country (Flanders). The latter region is more connected to the Anglo-Saxon countries and their traditions [11].

The afore-mentioned discussions between practitioners, policymakers and researchers clearly illustrate a clash of treatment and research paradigms. Consequently, the aim of this article is to elucidate implicit assumptions of evidence-based medicine and what may be its implications for substance abuse treatment. We want to clarify which paradigm is behind the evidence-based approach and whether, by the dominance of this paradigm, some treatment approaches are over- or undervalued. First, we will examine the origins of evidence-based medicine and its underpinning paradigm of care. Second, we will analyze this and other paradigms and the criticism they inflict, and discuss whether an integration of different paradigms is necessary to benefit the 'human prerogative' of care. This 'human prerogative' implies that a modernist, humanistic approach is seen as a prerequisite for every action and intervention in substance abuse treatment [12] and may offer opportunities to demonstrate similarities rather than dogmatic antitheses in the basic assumptions about evidence-based practice.

Evidence-Based Medicine

Evidence-based medicine is a movement that originated under the impetus of a large coalition of physicians, researchers, professors and policymakers to improve the application of results from experimental scientific research in clinical practice [13–15]. It has been defined as '*… the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating best research evidence with clinical expertise and patient*

[1] During this conference a first draft of this paper has been presented and was published in Greek in the Proceedings of the Society & Mental Health Conference, pp. 53–62.

values' [16, p. 1]. An important exponent of this movement is the international Cochrane Collaboration, which was founded by the Scottish professor Archie Cochrane [17]. His ideas were at the basis of the establishment of the Cochrane Library, a database of systematic reviews concerning a wide range of interventions for any kind of health problem [18].

In the evidence-based discourse, evidence is graded according to the methods used to collect it. This resulted in criteria to assign a level of evidence (e.g. 'strong', 'some' or 'no' evidence) for the effectiveness of interventions, based on the number, nature and quality of studies about this intervention (cf. [8, 19, 20]). According to these criteria, RCTs or 'randomized controlled trials' are considered to be the 'gold standard', followed by non- or partially randomized quasi-experimental studies, other quantitative research designs (e.g. correlational studies) and qualitative research (e.g. case studies). In various review studies, publications have been selected and classified on the basis of such criteria, leading to conclusions concerning the evidence for the effectiveness of interventions [20–22]. For example, the 'Mesa Grande' study [23], a meta-analysis of clinical trials, has compared various treatment interventions for alcohol abusers and classified these according to their degree of evidence.

Although such classifications are not always univocal, it can be concluded that there is mainly evidence for the effectiveness of various pharmacological interventions (e.g. benzodiazepines and carbamazepine; methadone and buprenorphine) for the treatment of alcohol and opiate abuse [21, 24–28]. Further, there is evidence for the effectiveness of some psychosocial treatments, mainly specific, brief and behavioral interventions (such as cognitive behavioral therapy, community reinforcement approach, motivational interviewing, contingency management, brief interventions and multidimensional family therapy) [11, 20]. On the other hand, there is not (yet) much evidence for the effectiveness of other widely implemented psychosocial interventions, such as therapeutic communities, psycho-education, relapse prevention, case management, social skills training, psychotherapy, counseling or psychodynamic therapy. No evidence is available for the effectiveness of acupuncture, educational lectures, confrontational approaches and compulsory participation in self-help groups [2, 29].

The assumption behind these classifications is that treatment approaches and aspects can be assessed—and even compared and classified—based on experimental evidence. This tendency is closely related to the empirical-analytical paradigm of care, which will be discussed and compared in the next section with other paradigms of care, namely the phenomenological-existential and the critical post-structural paradigm of care.

It is our basic assumption that research and science have to contribute to the further development of mankind. Each of these different paradigms offers a specific contribution to some specific problems and challenges. The human condition is the prerogative of free, but responsible decision-making from scientific paradigms that underpin treatment systems. This process does not exclude one or another option, but examines carefully which paradigm(s) contribute(s) in what situation to the best solution. From this point of view, the different paradigms do not exclude, but rather complement each other: in their search for the best answer in a given situation, they try to find the most suitable treatment and do the best for mankind. Whatever 'the best' may be, it has to be the exponent of a meaningful, significant flexible process of a methodical and systematic search or action for an expected valuable solution, free of dogmatic premises. This is what we call the 'human prerogative of care' and various research paradigms may be used to achieve it.

Diverse Paradigms of Care

The Empirical-Analytical Paradigm of Care

In the empirical-analytical paradigm of care, treatment is conceived as a coherent totality of causal conditional relations which can be analyzed in their composing parts and can be defined separately. Evidence-based medicine is underpinned by this paradigm. In its purest form, it raises experimental evidence to rule over other forms of knowledge. Certain study designs, such as meta-analyses and randomized trials, are thought to be less vulnerable to bias and, therefore, provide 'superior' evidence [30]. Interventions in substance abuse treatment are subdivided into (good) practices that have been proven to work (or not) and that are based on evidence (or not). This paradigm of care is most closely related to behavioral treatment approaches.

The Phenomenological-Existential Paradigm of Care

From a phenomenological-existential perspective, treatment is considered to be a methodical approach that involves the whole person and his or her social network and that aims at facilitating (mental) health and well-being. Or, as treatment was traditionally defined, as 'a range of interventions which are intended to remedy an identified drug-related problem or condition with a view to a person's physical, psychological or social well-being' [31]. Referring to interventions intended to improve someone's well-being implies per definition meaningful action ('to become well through the act of intervention'). In this context, treatment consists of taking adequate action in special situations for helping or supporting individuals.

In the phenomenological-existential paradigm, treatment success is measured based on the reported experiences (of well-being) concerning the intervention. It is argued that human motives, social interactions and beliefs—in short, human life and activities in general—are far too complex to be reduced to statistical analyses that aim at universally valid evidence. In order to reach a scientific and causal explanation of proceedings and effects, a rational and/or empathic interpretative understanding is needed [32]. This phenomenological-existential paradigm of care is clearly connected to the therapeutic community and self-help approaches in substance abuse treatment; it stresses self-actualization and growth and is inherent in humanist psychology and pedagogy.

The Critical Post-Structural Paradigm of Care

From a third, post-modern, post-structural perspective, treatment should be discussed from a critical position towards society, in which concepts like inclusion, self-advocacy and emancipation of the poor and weakest prevail [33]. The grand theory of science and its associated methodologies no longer make sense, but should be replaced by narratives [34]. As long as we are captured by our genealogy and mental (language) structures, the subject cannot become an actualized self [35]. Humans have to deconstruct their world to get some grip on reality (cf. [36]), which is characterized by uncertainty and relativity. Human rights for every citizen and the rights to quality of life and quality of care are guiding principles in disability studies [37], including the support for and treatment of substance abusers. This critical post-structural paradigm of care is closely linked with the harm-reduction

movement, in which social inclusion, (self-) advocacy and emancipation are central concepts, and that takes a critical position towards the conservative values of society.

Critical Reactions to Evidence-Based Medicine

From an Empirical-Analytical Point of View

From an empirical-analytical point of view, mainly methodological questions and concerns are expressed concerning the actual tendency towards more evidence-based practice, although it starts from the same fundamental ideas. Some authors emphasize statistical problems when searching for convincing evidence in comprehensive 'box-score reviews' [38–40]. They refer to issues such as low/variable statistical power to demonstrate treatment effects, varying statistical tests, diverse comparison groups across studies, and lack of consistent data on client characteristics.

Because some insurmountable problems are intrinsic to the experimental, randomized and controlled setup, several researchers choose 'minimal bias designs' (e.g. [41–43]). Still, these criticisms are of secondary nature and do not touch 'the heart' of the approach itself.

From a Phenomenological Point of View

Phenomenologists criticize the lack of distinction between professional treatment as a compilation of good practices and evidence-based treatment as one of its constituting elements [44]. They call attention to the constriction and simplification of various treatment problems into elements that can be controlled by an empirical-analytical research design [38]. The evidence-based paradigm may underestimate the essence of treatment as meaningful action and deny its phenomenological nature that requires qualitative (empirical) research [31]. They state that the use of evidence-based practice and research findings requires an understanding of the processes by which implicit and explicit knowledge and beliefs are constructed and that guide the daily practice of treatment [45]. They further stress the importance of clinical freedom and the need to find a balance between the 'art of medicine' and evidence-based interventions, even if this might be a false dichotomy [46]. Evidence-based medicine does not provide a means to integrate other, non-statistical sources of medical information, such as professional experience and patient-specific factors [30], although their importance is recognized by proponents of EBM.

Phenomenologists argue that, if evidence is used as part of action, it inevitably becomes an integral part of meaningful action. The 'act' of using evidence-based approaches is a prerequisite for the method itself. According to De Leon [47, 48], action in the field of substance abuse treatment unarguably implies self-selection. It is not possible to enjoy the benefits of a remedy, such as medication, without the act of taking it (or not taking it, if one wants to falsify this induction or hypothesis). According to this rationale, the 'act of taking' is of greater importance than the evidence itself. From a more global perspective, one can also question the idea that addiction is a chronic relapsing disorder (cf. [49]). For, not all substance abusers relapse, but some stay sober. Moreover, addiction is not only a medical condition but is determined by a complex interaction of psychological, social, hereditary and biological factors [50, 51].

The ultimate consequence is that *neither* psychiatry *nor* therapeutic communities *nor* self-help groups *nor* psychological counseling can be evidence-based, but only the interventions that are part of it. However, these interventions do not determine the complexity of the treatment approaches they are part of.

From a Social Critical Point of View

Poststructuralists criticize the denial of post-modern approaches and the lack of collaborative, empowering and inclusive methodologies in evidence-based medicine [52, 53]. They state that the negation of post-structural approaches in science stands for conservatism and a lack of social activism and compassion for the underprivileged [54]. According to social critical practitioners, the underprivileged have to be empowered in order to achieve the full civil right of free choice and self-selection of treatment. The act of self-selection is seen as an integral part of the act of treatment but is in essential contradiction with the principle of randomization. Alternatively, they advocate for a replacement of the search for effectiveness and efficiency by assessing and monitoring quality of care and quality of life [55]. It should be clear that both quality concepts do not necessarily correlate—on the contrary [37, 56]. Last but not least, the critical social perspective questions evidence-based medicine as it is adopted by the current neo-liberal movement towards managed care and compartmentalization of care into units, modules and functions [57]. This may lead to dramatic cutbacks in funding of health care and preserve evidence-based interventions for the 'higher' social classes, although this was not the intention of the founders and proponents of evidence-based medicine. It could go so far that health resources for the rich are preserved—due to governmental priorities—at the cost of essential needs of the poor and underprivileged.

The social critical point of view can be combined with the evidence-based paradigm, as is illustrated in controlled heroin trials in the Netherlands [58] and Germany [59] in which evidence is applied as part of a critical social commitment against traditional and conservative societal forces.

Consequences of Methodo- and Ethnocentrism for Substance Abuse Treatment

From a Methodocentric Point of View

The methodocentric scientific point of view rigorously uses one specific methodology for evaluating any type of intervention and promotes the exclusive use of one 'scientific' paradigm [60]. In the case of empirical-analytical (c.q. evidence-based) research, the guiding principles are observable behavior, objectivity and generalization, falsification of hypotheses, explanation, prediction and control based on facts. Phenomenological research concerns meaningful action, critical dialogue, inter-subjectivity and particularity, and a cycle of planning, action, evaluation, change and improvement, based on subjective interpretations [61]. Post-modern post-structuralism is about social criticism and emancipation, deconstruction, inclusion and diversity, uncertainty, narratives and relativity. Consequently, clear-cut interventions (such as contingency management or CBT), global approaches (such as therapeutic communities or Alcoholics Anonymous) and progressive social practices (such as needle exchange or controlled heroin trials) and alienating social institutions (such as prisons) are studied solely from an empirical-analytical or a phenomenological or a post-structural point of view.

This kind of methodocentrism is typical for evidence-based medicine, in which the effectiveness of all treatment approaches and interventions is assessed according to the same criteria and standards, thus elevating experimental research to a higher level than any other type of research.

From an Ethnocentric Point of View

The ethnocentric scientific point of view considers the method used as a social construction and promotes the application of a methodology that tight-fits the nature of the type of intervention [62]. Consequently, behavioral approaches (with their focus on observable behavior) can exclusively be investigated from an empirical-analytical point of view, while comprehensive approaches that link various interventions into 'action' require a phenomenological point of view. Progressive social practices and alienating social institutions should, from this ethnocentric perspective, be evaluated from a post-structural critical point of view.

From an Integrative Point of View

The integrative scientific point of view searches for the integration of diverse types of interventions as well as methodological approaches. It means that various treatment modalities, paradigms of care and research methodologies can alternatively go together [57]. Consequently, behavioral interventions, therapeutic communities, self-help groups, harm reduction and prison treatment for substance abusers can complement each other and all have their own specific value. Therefore, clear-cut interventions, global approaches and progressive social practices need to be evaluated from an analytical-empirical point of view, as well as from a phenomenological and post-structuralist critical point of view.

In the following section, we discuss why the dialectical integration of diverse approaches (empirical-analytical, phenomenological, and social critical)—and thus of evidence, existence and social emancipation—could benefit the human prerogative of care. By doing so, we want to offer practitioners and researchers an alternative framework for addressing the ever-increasing demand for evidence-based practice.

Towards the Integration of Paradigms and the Search for a Human Quality of Care and Life: Actual Paradoxes and Future Options

Present-day substance abuse treatment is characterized by a compelling demand for evidence-based practice that applies and promotes the empirical-analytical paradigm of care and science. Still, practitioners appear to be rather hesitant or even reluctant to adopt this tendency [1]. The predominance of one paradigm implicitly—and maybe not intentionally—leads to a hierarchy among treatment modalities, since these are underpinned by different methodological paradigms. Such a hierarchy implies the loss of self-help and therapeutic community approaches, but also—and at first sight paradoxically—the promotion of harm reduction approaches. The marriage between two orthodoxies—experimentalism and harm reduction—can mainly be explained by the search for certainty (evidence) in an uncertain post-modern world (i.e. the search for reduction of harm). The former is denominated as 'managed health care', the latter as 'public safety', illustrating a neo-liberal approach which at the same time promotes individual freedom, hedonism and

even the right to controlled drug use, and on the other hand stresses the need for control, security and rationalization.

However, in their search for a better quality of care and life, evidence and emancipation miss their third partner: existence and humanism. If we want to enhance human quality of life and care for substance (ab)users, a further integration of the different paradigms of care is needed. In order to elevate the quality of care as well as the quality of life of substance (ab)users, evidence from experimental research, the self-actualizing existence of people and the search for social emancipation should be combined. In this new search for an integration between parts and totality, various complementing (partial) approaches alternatively go together in their never-ending pursuit of unity and transformation of actual conditions.

In such an integrated model, the going together of each element's excluding aspects of reality is referred to as *complementarity* [63]. The opposites are interchangeable and may replace each other in a series of transformations. This means that the "system as a whole shifts to a new, higher order, a more complex structural form of which the parts are governed by a new set of functional properties and are characterized by a new set of statistical parameters" [64, p. 380]. This dynamic dialectical process includes cycles of disorganization and the transformation of activities, meanings, self-development and relations. This understanding of reality is founded on two premises: 1) that everything is interconnected; and 2) that a living organism cannot be reduced to its physical parts. The opposing terms *sum* and *parts* are in fact misleading, because their relation is intrinsic as well as external.

The mechanism behind this search for holistic unity is called *integration* [65]. It transforms 'thesis' and 'anti-thesis' (part and counterpart) to a new unity or synthesis. In other words, once unity is reached, a new process starts, a transformation is realized and a higher order reached. Consequently, from this point of view, evidence-based medicine (the empirical-analytical paradigm), therapeutic communities (the phenomenological-existentialist paradigm) and harm reduction (the social critical paradigm) exclude each others' reality only at first sight. In fact, they are internally connected. This interconnection is the human interconnection—the human prerogative—the human dedication to achieving the best solution for persons with substance (ab)use problems.

Once we accept this internal link, we can start an open, methodical, meaningful and valuable search for the best answer to this or that problem, based on the well-being and human dignity of the substance (ab)using person. As a human being, the latter is also an interconnected and integral part of this 'best' choice. The underlying paradigms of care are no longer conflicting; instead they complete each other as a human endeavour. By doing so, we can transcend postulated and presupposed solutions.

In summary, various treatment approaches and methodologies simultaneously co-exist, go alternately together and strive for unity through integration, but once unity or synthesis is reached they dissipate and transform the closed system into a new open one. In other words, if open systems such as therapeutic communities or psychiatric hospitals use motivational interviewing, they do so in a process of transforming treatment towards a higher level of functioning. Psychiatric treatment and therapeutic communities interact as a whole with their composing parts. There is no reason to study therapeutic communities or AA group meetings as 'methods' and compare them with other 'partial interventions', as there is no reason to compare psychiatry with other 'global interventions' such as TC or AA. Within this context, 'medical treatment as an art' versus 'evidence-based medicine' is just a false dichotomy: they simply complete each other in the search for a better integrated medicine. Similarly, the ethical questions concerning 'at random' or 'minimal bias' methodologies can be considered as two sides of the same coin in the search for the best evidence for current practice.

Our position on the 'integration of paradigms' might have important consequences for substance abuse treatment and it provides a theoretical framework underpinning the application of 'integrated treatment systems' [57]. Such an integrated and comprehensive system of treatment modalities (including drug-free treatment, substitution therapy, harm reduction initiatives, and other health, psychiatric and social services) provides the opportunity to tailor services according to individuals' needs and expectations. Case management is an important method in such an integrated network of services, as it provides the ability to link people to appropriate services [66] and to guarantee coordination and continuity of care [67]. One of the prerequisites of an integrated treatment system is that no treatment modality is in essence better than another [57]: various treatment approaches are not competing, but may all have their value for someone with substance abuse problems at a certain moment in a certain situation throughout their lifespan.

Conclusion

Ultimately, our critical analysis of evidence-based and other paradigms of care in substance abuse treatment led to the conclusion that each of these approaches is underpinned by another scientific paradigm. We distinguished between the empirical-analytical (e.g., evidence-based medicine), phenomenological-existentialist (e.g., therapeutic communities) and social critical paradigm (e.g., harm reduction). We examined the consequences of methodo- and ethnocentrism for substance abuse treatment and found that each of these paradigms is to a certain extent reductionist. Therefore, we chose an integrated paradigm of care. We argued that care approaches are interconnected by a common human dedication to achieving the best answer for substance abusers' treatment demands. We called this interconnection 'the human prerogative of care' and accepted as a logical consequence that no single treatment system can solve all substance abuse problems. Real human commitment consists of an open, methodical, meaningful search for the best solution for a certain problem. This process implies doubt and uncertainty, but is ultimately based on free and responsible decision-making, in interaction with the client. It assumes a treatment system that gives full opportunity and authority to a broad spectrum of interconnected treatment modalities and services, all with their own explicit identity, strengths and weaknesses (i.e., an integrated treatment system).

All of this requires an interaction between evidence, facts and methodological security and the uncertainty of scientific doubt. Scientific evaluation of substance abuse treatment from diverse points of view can contribute greatly to the improvement of the quality of care and life of substance users and to the effectiveness and efficiency of substance abuse treatment. It is in fact this alternately going together of evidence, existence and emancipation that constitutes the 'human prerogative of care'.

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